STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150166	A. BUILDING 00 B. WING	07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE HOSPITAL	9301 CONNECTICUT DR CROWN POINT, IN 46307

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S000000	This visit was for a State licensure survey. Date of Survey: 07/21-22/14 Facility #: 006619 Surveyors: ReBecca Lair, LCSW Medical Surveyor Jacqueline Brown, RN Public Health Nurse Surveyor Lynnette Smith Laboratorian QA: claughlin 07/29/14	S000000		
S000362	410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(d)(6)(A)(B)(C)(D)(E)(F) (d) The governing board is responsible for assuring that quality patient care is provided. In accordance with hospital policy, the governing board shall do the following: 6) Ensure that the hospital does the following:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	(A) Establish written protocols to identify potential organ and tissue donors. (B) Has written policies and procedures for the facilitation of organ and tissue donations, including procurement. (C) Inform families or authorized persons of potential organ and tissue donors of the option of donation on admission or at the time of death of a potential donor. (D) Use discretion and sensitivity in contacts with potential organ donor families. (E) Notify the appropriate procurement organization of potential organ donors. (F) Establish membership in the organ procurement and transplantation network if the hospital performs transplants. Based on document review and employee interview, the facility failed to notify the appropriate organ procurement organization, per contract, of all hospital deaths. Thus the facility failed to notify procurement organization of all potential organ donors. Findings: 1. Review of the contract between the hospital and the Gift of Hope Organ & Tissue Donor Network indicated the hospital shall provide a "timely referral to	S000362	Responsible person: CNO/COO 1. Steps Taken: o Education given to entire staff on in-patient unit. The education included: - Process to follow upon death of patient -- Call Gift of Hope -- Fill out Gift of Hope form -- Place completed form in the patient chart -- Document death in the “death log book” (kept on in-patient) -- Place chart in the CNO/COO mailbox 2. Prevention Plan o The CNO/COO will review every death chart to ensure completeness and accuracy of Gift of Hope forms. o The CNO/COO will review the death log (from Medical Records) monthly. This	07/24/2014

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	Gift of Hope of all individuals who have died or death is imminent". 2. Donation Activity Report 2013 indicated the hospital notified Gift of Hope of 12 deaths in 2013. Death Register January 2013-July 2014 Pinnacle Hospital report indicated 13 deaths occurred in 2013 and 12 deaths were reported to Gift of Hope. Thus the hospital failed to show evidence that all deaths were reported. 3. Interview with Employee #A1 on July 22,2014 at 2pm verified the above information.		will be compared to “death log book." o The CNO/COO will compare the quarterly reports from Gift of Hope with death log report from Medical Records to ensure completeness. o Education regarding the Gift of Hope process will be given quarterly to nursing staff and in orientation to all new nursing staff.	
S000952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on review of policies and procedures, patient records, validated cooler logs, and staff interview, the nursing service failed to ensure blood	S000952	For Item 2a. Responsible person: CNO/COO 1. Steps Taken: o Education given to entire staff on in-patient unit. This education will be given to the	07/24/2014

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	transfusions were administered in accordance with approved medical staff procedures for 9 (Patient #L1-L9) of 9 patient records reviewed. Findings include: 1. Review of policies / procedures on 7-22-14 between 9:00 AM and 9:50 AM revealed a policy / procedure titled: "Blood, Blood Products, Derivatives Administration," policy number "PCS-18," last reviewed "February 2013," which read: "Blood transfusion must be initiated within thirty (30) minutes from the time the bag is removed for the validated cooler." and "...Reassess Vitals (T, P, ans(sic) B/P)...At Completion (sic) of Transfusion (sic)..." 2. Review of patient records on 7-22-14 between 9:50 AM and 11:00 AM and review of validated cooler logs on 7-22-14 between 12:45 PM and 12:50 PM indicated the following: a. Patient #L6 had a blood transfusion initiated on 5-9-14. The time the transfusion was started was not documented. The time the transfusion was discontinued was "1600" and the "Post Transfusion" vital signs were documented at "1555," 5 minutes before the transfusion was discontinued. b. It was unable to be determined if the		nursing staff quarterly and in general orientation. The education included: - Blood Transfusion policy -- Review of timelines for initial and reassessment of vitals (initiation, during, and completion) - After each blood transfusion, the patient record will be reviewed by the RN transfusing the blood and the shift charge nurse to ensure accuracy of each entry and compliance with the policy. 2. Prevention Plan o Compliance will be monitored by having the patient record reviewed by the RN transfusing the blood and the shift charge nurse to ensure accuracy of each entry. o All blood transfusion forms will be monitored for compliance and accuracy by the CNO/COO and the charge nurse. For Item 2b. Responsible person: CNO/COO 1. Steps Taken: o The following statement was added to the Temperature monitor form on 7/24/2014. - Removal of blood product from cooler will be documented including date, time and initials of RN removing the unit. o Education of the addition was given to entire staff on in-patient unit. This education will be given quarterly to the nursing staff and at general orientation to all new nurses. 2. Prevention Plan o Compliance will be monitored by having the patient record reviewed by the RN transfusing the blood and the shift	

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	transfusions were initiated within 30 minutes from the time the bag was removed from the validated cooler because time the unit of blood was removed from the cooler was not documented on the blood administration record or validated cooler logs for the following patients: Patient # Date of Transfusion _____ L1 7-18-14 L2 5-8-14 L3 5-16-14 L4 4-17-13 L5 5-8-14 L6 5-9-14 L7 4-15-14 L8 5-13-14 L9 5-21-14 3. In interview on 7-22-14 between 12:45 PM and 12:50 PM, Staff Member #L21 acknowledged that there was no documentation to determine when the units of blood were removed from the validated coolers.		charge nurse to ensure accuracy of each entry. o All blood cooler temperature logs will be monitored for compliance and accuracy by the CNO/COO and charge nurse.	